AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING  COMPLE	ETED	
	COMPLETED	
155637 B. WING 03/21/20	)11	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE		
6685 E 117TH AVE		
CHICAGOLAND CHRISTIAN VILLAGE CROWN POINT, IN46307		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY)	DATE	
K0000 A Life Safety Code Recertification K0000		
and State Licensure Survey was		
conducted by the Indiana State		
Department of Health in		
accordance with 42 CFR 483.70(a).		
Survey Date: 03/21/11		
Facility Number: 001198		
Provider Number: 155637		
AIM Number: 100471000		
Surveyor: Bridget Brown, Life		
Safety Code Specialist		
At this Life Safety Code survey,		
Chicagoland Christian Village was		
found not in compliance with		
Requirements for Participation in		
Medicare/Medicaid, 42 CFR		
Subpart 483.70(a), Life Safety		
from Fire and the 2000 edition of		
the National Fire Protection		
Association (NFPA) 101, Life Safety		
Code (LSC), Chapter 19, Existing		
Health Care Occupancies, Chapter		
18, New Health Care Occupancies		
and 410 IAC 16.2.		
and 410 IAC 10.2.		
This facility was located on the		
west side of the first floor and the		
entire lower level of a two story		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

OVPC21

Facility ID:

001198

If continuation sheet

TITLE

PRINTED: 04/13/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155637		A. BUII	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED 03/21/2011	
	PROVIDER OR SUPPLIER		B. WIN	STREET A 6685 E	DDRESS, CITY, STATE, ZIP CODE  117TH AVE  N POINT, IN46307	1 00.2	
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE
	two separate by addition of 8 by Building 1 was 1, 2003, therefin accordance with 19. Building 3 be of Type II (1 fully sprinklere 8 additional roothe first floor succordance with The facility was of Type II (111) was fully sprinklere alarm smoke detections a fire alarm smoke detections accordance with the capacity for census of 129 survey.  Quality Review by I Safety Code Special 03/24/11.  The facility was compliance with	built prior to March ore it was surveyed with LSC Chapter was determined to 11) construction, d, and consisted of oms (251–258) on urveyed in h LSC Chapter 18. If determined to be construction and construction					

001198

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155637  A. BUILDING  B. WING		COMP	(X3) DATE SURVEY COMPLETED 03/21/2011				
NAME OF PROVIDER OR SUPPLIER  CHICAGOLAND CHRISTIAN VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE CROWN POINT, IN46307					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		155637	B. WING			03/21/2011	
			D. 171111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				117TH AVE		
CHICAG	OLAND CHRISTIAN	N VILLAGE			N POINT, IN46307		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF C		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0018	Based on obser		K0018		K 018 E1. What is the correcti action taken for the resident	ive	04/20/2011
SS=E	interview, the f	•			found to be affected by the		
	ensure there w	ere no impediments			deficient practice?The Social		
	to closing and	latching doors			Service Director office door ha		
	protecting a co	rridor opening in 1			been repaired enabling the late	ch	
	of 10 smoke co	ompartments. This			of the door to engage. Social	to	
		ce affects staff,			Service has bee nreinstructed keep the door close. 2. How	iO	
	· •	residents in the			other residents have the poten	ıtial	
					to be affected by the same		
	Reciaiiii i Siilok	e compartment.			deficient practice will be identif	fied	
				and what corrective action will			
	Findings include:				taken. All corridor doors in faci	lity	
					will be inspected by the		
	Based on obser	vation with the			maintenance department to ensure proper door closure. 3.		
	maintenance di	irector on 03/21/11			What measures will be put into		
		ne corridor door to			place or what system changes		
		ces Director's office			will be made to ensure that the		
					deficient practice does not		
		open with a door			reoccur. A. Maintenance		
	stop. When the	-			Supervisor and other facility st		
		oor failed to latch.			will be re-inserviced on the pro	-	
	Upon closer ins	spection by the			door closer and the procedure reporting concerns to the	iUi	
	maintenance di	irector at the time			maintenace department. B.		
	of observation,	a magnet was			Proper door closures will be		
		nt the latch from			addressed immediately as the	y	
	engaging. The				occurred and recorded on		
		at the time of			maintenance report log that it		
	_				has been corrective or	_	
		he door mechanism			repaired. 4. How the correctiv actions will be monitored to	<del>-</del>	
		e been tampered			ensure that the deficient pract	ice	
	with.				will not reoccur i.e. what quali		
					assurance will be put in place		
	3.1-19(b)				Maintenance staff will conduc	t	
					random corridor checks one		
					door per hallway per month a		
					these checks will be reviewed	Dy	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	155637	A. BUILDING		COMPLETED 03/21/2011	
		100001	B. WING	ADDRESS, CITY, STATE, ZIP CODE	00/21/2011	
NAME OF I	PROVIDER OR SUPPLIER	l .		117TH AVE		
	OLAND CHRISTIAN		CROW	N POINT, IN46307		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	the maintenance supervisor a forwarded to the Administrator /Designee. The Administrator /Designee will report findings to Q/A committee .This will be ongoing as a component of the preventative maintenance program.	nd	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155637		A. BUII	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 03/21/2011	
	PROVIDER OR SUPPLIER			6685 E	ADDRESS, CITY, STATE, ZIP CODE 117TH AVE N POINT, IN46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) COMPLETION DATE
K0029 SS=E	smoke comparisoiled linen recthan 32 gallons foot area were equipped with Sprinklered has required to be closing doors of close automatic activation of the This deficient pusitors staff are the Reclaim II, smoke comparison for the Re	acility failed to bus areas in 3 of 8 timents such as eptacles of more swithin a 64 square located in a room self closing doors. cardous areas are equipped with self or with doors that cally upon e fire alarm system. bractice affects all ad 68 residents in Haven, and Lower D timents.  e: e: evations with the frector on 03/21/11 p.m. and 12:55 im II exit corridor collection point for	K00	029	K 00291. What is the correctivaction taken for the resident found to be affected by the deficient practice? Reclaim 2, Haven and Edens D hall barrels were moved at the time that maintenance supervivas made aware and staff was informed that if laundry barrels are not in use they need to be stored. 2. How other resident have the potential to be affected by the same deficient practice be identified and what correctivaction will be taken. At the time finding staff were informed of the acceptable practice of moving laundry barrels on all units. 3. What measures will be put into place or what system changes will be made to ensure that the deficient practice does not reoccur. Staff will be re-inservion proper useage of laundry barrels and storage. 4. How the corrective actions will be monitored to ensure that the deficient practice will not reoccive. What quality assurance will put in place. Maintenance staff while performing daily rounds document laundry barrel used and report findings to Maintenance Supervisor /Designee who will track findin Maintenance Supervisor will report finding to Administrator /Designee who will report finding to Q/A monthly for six month.	risors sed will ve e of the the of the few libers of the ge gs.	04/20/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155637			(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION	COMI	(X3) DATE SURVEY COMPLETED 03/21/2011	
	PROVIDER OR SUPPLIER		STREET A 6685 E	ADDRESS, CITY, STATE, ZIP COI . 117TH AVE N POINT, IN46307	DE		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
	each had a cap which was conf	irector at the times					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155637			A. BUI	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 03/21/2011	
NAME OF P	ROVIDER OR SUPPLIER		<b>D.</b> (12)	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
CHICAG	OLAND CHRISTIAN	VILLAGE			: 117TH AVE 'N POINT, IN46307			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE	
K0038	Based on obser	vation and	K00	38	F 00381. What is the corrective action taken for the resident	/e	04/20/2011	
SS=E	interview, the f				found to be affected by the			
	_	exit corridors in 3			deficient practice? Reclaim			
		npartments were			2, Haven and Edens D hall barrels were moved at the			
	not used for sto 7.1.3.2.3 requi				time that maintenance superv			
	· •	not be used for			was made aware and staff was			
		th the potential to			informed that if laundry barrels are not in use they need to be			
		ts use as an exit.			stored. Hoyer lift and linen car			
					reclaim 2 was removed at the			
	LSC 7.1.10.1, "Means of egress shall be continuously free of all obstructions or impediments to				time of observation. Haven ho lift and wheelchair were reloca	· .		
					at time of observation . Eden [			
		in case of fire or			hall gerri-chair , 4 laundry barr			
	other emergen	cy use." This			,hoyer lift and a bag of trash w removed at time of observation			
	deficient practi				How other residents have			
	· ·	nd 68 residents in			potential to be affected by the			
	the Reclaim II,	Haven, and Lower D			same deficient practice will be identified and what corrective			
	smoke compar	tments.			action will be taken. At the time	e		
	Findings include:				of the findings staff was inform of the acceptable practice of moving the laundry barrels ,resident equipment ar	ned		
	Based on obser	vations with the			trash . 3. What measures will			
		rector on 03/21/11			put into place or what system changes will be made to ensur	,		
	between 12:20	•			that the deficient practice does			
	_ =	im II exit corridor			not reoccur. Staff will be			
	egress path wa				re-inservice on proper useage	of		
	·	t for two laundry			laundry barrels,resident equipment and trash which will	, l		
	·	r lift and linen cart.			include storage of laundry			
		remained in place			barrels,resident equipment and	d		
		t 4:10 p.m. The			trash storage. 4. How the corrective actions will be			
		corridor egress			monitored to ensure that the			
	path was used	as a collection			deficient practice will not reocc	cur		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: OVPC21 Facility ID: 001198

If continuation sheet Page 8 of 20

PRINTED: 04/13/2011 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637	li i		INSTRUCTION	(X3) DATE SURVEY COMPLETED 03/21/2011	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  6685 E 117TH AVE  CROWN POINT, IN46307				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Hoyer lift and a 4:15 p.m. on 0 no change in the corridor. Four three geri chair located in the L At 5:00 p.m. or of trash was adequipment stored the maintenant the times of obwere aware the	aundry barrels, a wheel chair. At 3/21/11, there was ne equipment in the laundry barrels, s and a Hoyer were lower D corridor. n 03/21/11, a bag ded to the red in the corridor. ce director said at servation, staff corridors should oment not in use.			i.e. what quality assurance will put in place. Maintenance stat while performing daily rounds document laundry barrel resid equipment and trash useage a report findings to Maintenance Supervisor /Designee who will track findings. Maintenance Supervisor will report finding to Administrator /Designee who report findings to Q/A monthly six month.	ff will ent end e I	

001198

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		155637	B. WING			03/21/2011	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			6685 E	117TH AVE		
	OLAND CHRISTIAN				N POINT, IN46307		
(X4) ID		TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	•	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	17.00	TAG	k 00501. What is the correctiv		DATE
K0050		cord review and	K00	50	action taken for the resident	е	04/20/2011
SS=C	interview, the f	-			found to be affected by the		
	ensure all elem	ents of fire drills			deficient practice? A.We cannot	ot	
	were included of	on documentation			correct the actual time of the fi	re	
	of fire drills for	2 of the past 4			drill docuemntation but in the		
	quarters includ	ing the time the			furture times will be documeted by the cannot correct the times.		
	drill was condu	cted. This deficient			that fire drill were held but in the		
	practice affects	all occupants.			future we will conduct fire drill		
	p: 0.000	ш. особрано.			various time and shifts. 2. Ho	w	
	Findings includ	la:			other residents have the poten	itial	
	Findings include:				to be affected by the same	S a d	
					deficient practice will be identified and what corrective action will		
		ew of Monthly Fire			taken. All residents have the	bc	
	-	past year with the			potential to be affected by		
		irector on 03/21/11			deficient practice. 3. What		
	at 1:15 p.m., fi				measures will be put into place	e or	
	documentation	did not include the			what system changes will be made to ensure that the deficie	ont	
	actual time of	the drill. The time			practice does not reoccur. A.	ziil .	
	of each drill wa	is noted as 7–3,			Exact time of fire drill will be		
	3–11, or 11–7	on the record			docuemtned on quarterly Fire		
	during the third	d and fourth			Drill form. B. Three fire drills		
	quarters of 201				be conducted at various times	to	
	•	irector said at the			include all shift. 4. How the corrective actions will be		
	time of record				monitored to ensure that the		
					deficient practice will not reocc	cur	
		ecific times fire ducted should also			i.e. what quality assurance will		
					put in place. The Administrator	•	
	be included in	the documentation.			/Designee will audit Fire Drill documentation to ensure		
					that time is documented on Fir		
	3.1-19(b)				Drill form and also that fire drill	-	
	3.1-51(c)				are conducted on all three shif	t at	
					various times. The results of		
		cord review and			audits will be presented to Q/A	١	
	interview, the f	acility failed to			monthly for six months.		
	conduct fire dr	ills at varied times					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155637		(X2) MULTIPLE C  A. BUILDING  B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/21/2011			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  6685 E 117TH AVE  CROWN POINT, IN46307				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION		
	_	past 4 quarters. practice affects all					
	Findings includ	e:					
	Drill(s) with the director on 03/p.m., first shift p.m.) fire drills 11:30 a.m. (20 11:00 a.m., and 2010. Docume drills (3:00 p.m conducted at 6 first quarter in p.m. and 7:30 third and fourt Third shift (11: drills were conducing the first and during the 2010. The thir was not record be determined conducted at a from the 5:30 a during the four The maintenan agreed at the ti	(7:00 a.m3:00) were conducted at 11), and 9:40 a.m., d 10:30 a.m. in ented second shift in-11:00 p.m.) were is 30 p.m. during the 2011 and 7:00 p.m. during the h quarters of 2010. 00 p.m7:00 a.m.) ducted at 4:00 a.m. is quarter of 2011 second quarter of d quarter drill time ed and it could not if the drill was my time removed a.m. drill conducted ith quarter of 2010. ce supervisor					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155637		A. BUILDING B. WING			COMPI 03/21/2	LETED	
NAME OF PROVIDER OR SUPPLIER  CHICAGOLAND CHRISTIAN VILLAGE			<u> </u>	STREET A 6685 E	DDRESS, CITY, STATE, ZIP CODE 117TH AVE N POINT, IN46307	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
	REGULATORY OR			I .	(EACH CORRECTIVE ACTION SHOULD	BE	

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DING		COMPL	ETED
		155637	B. WING			03/21/2011	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			6685 E	117TH AVE		
CHICAGOLAND CHRISTIAN VILLAGE				N POINT, IN46307			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
		LSC IDENTIFYING INFORMATION)	17.00		K 0051 1. What is the correcti	.vo	
K0051	1. Based on ob		K00	31	action taken for the resident	VC	04/20/2011
SS=F	interview, the f	•			found to be affected by the		
	ensure 1 of 3 fi	ire alarm panels in			deficient practice? A. An		
	an area not cor	ntinuously occupied,			automatic smoke detector whi		
	was provided w	ith automatic			supervises the annunciator fire control panel located in the en		
	smoke detectio	n to ensure			vestibule has been ordered. E		
	notification of a	a fire at the location			Smoke detector connected to		
	before it could	be incapacitated by			fire alarm system have been		
	fire. NFPA 72,	1-5.6 requires an			properly separated from air		
	automatic smo	ke detector be			supply. C. The air vent by corridor smoke detector near		
		location of each			room C has been relocated an	ıd is	
	-	rol unit which is not			now 38 inches from the smoke		
		rea continuously			detector. D. A sensitivity test v	will	
		ovide notification of			be performed on 144 smoke	11.6	
	a fire in that lo				detectors and will be placed in safety book. 2. How other	ше	
					residents have the potential to	be	
	deficient practi	ce affects aff			affected by the same deficient		
	occupants.				practice will be identified and		
					what corrective action will be	h -	
	Findings includ	e:			taken. All smoke detectors will checked during sensitivity test		
					will be completed by April	<del>9</del>	
	Based on obser				20,2011 3. What measures wi	ill	
	maintenance di	irector on 03/18/11			be put into place or what syste		
	at 12:35 p.m.,	a fire alarm control			changes will be made to ensur		
	panel (FACP) wa	as located in the			that the deficient practice does not reoccur. A. The maintenan		
	entry vestibule	which was not			staff will be re-inserviced relate		
	continuously o	ccupied and was			to Smoke Detector Regulation	ns	
	not electrically	supervised by a			and Codes. 4. How the		
	-	r. The maintenance			corrective actions will be		
	director agreed	at the time of			monitored to ensure that the deficient practice will not reocc	cur	
	_	e panel could be			i.e. what quality assurance will		
		y fire before an			put in place. Contracted service		
	<u> </u>	annunciated in the			will monitor and report to		
	alaini codia be	amanetated in the			sensitivity testing every two ye	esrs	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
		155637	B. WING			03/21/2011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				117TH AVE		
CHICAG	OLAND CHRISTIAN	JVIIIAGE			N POINT, IN46307		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	``			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	,	DATE	
	area.				and report findings to	:11	
				Maintenance Supervisor who will			
	3.1-19(b)				report findings to Q/A .  Maintenace will include		
					monitoring smoke detectors a	e	
	2 Pasadanah				part of Monthly Preventative		
	2. Based on ob				maintenace log which wil lbe		
	interview, the f	•			ongoing. MAintenance Superv	visor	
		detectors connected			/Designee will report monthly		
	to the fire alarr	n system in 1 of 6			findings to the Administrator		
	smoke compar	tments were			/Designee who will report		
	properly separa	ated from an air			findings to Q/A ongoing.		
	' ' ' ' '	72, 2-3.5.1 requires					
	spaces served	·					
	· ·	· ·					
		tors shall not be					
		airflow prevents					
	operation of th	e detectors. This					
	deficient practi	ce could affect					
	visitors, staff, a	and 22 residents on					
	Haven.						
	   Findings includ	lo:					
	Findings includ	le.					
	Based on obser	vation with the					
	maintenance d	irector on 03/21/11					
	between 12:15	p.m. and 4:15					
	p.m., a corrido	r smoke detector					
	l '	inches an the air					
	vent near room						
		irector confirmed					
		easurement and					
	_	ime of observation,					
	the air flow coเ	ıld impede the					
	function of the	smoke detector.					
					l		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155637		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY  COMPLETED		
		B. WING			03/21/2	011	
NAME OF PROVIDER OR SUPPLIER  CHICAGOLAND CHRISTIAN VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE CROWN POINT, IN46307				
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PERCEDED BY FULL  SC IDENTIFYING INFORMATION)	PRI	EFIX YAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
3.1-19(b)							
for 144 of 144 s was completed, reliable. NFPA 7 states, "Detector be checked withinstallation and eyear thereafter. required calibrat sensitivity tests idetectors have retheir listed and ranges, the length between calibrat extended to a myears. If the free extended, record caused nuisance maintained. In 2 where nuisance increase over the calibration tests performed.  To ensure each s within its listed a	cility failed to y documentation moke detectors current, and 12, at 7-3.2.1 r sensitivity shall in one year after every alternative After the second cion test, if indicate the emained within marked sensitivity th of time cion tests may be aximum of five quency is ds of detector alarms shall be cones or areas alarms show any e previous year, shall be smoke detector is and marked it shall be tested ing methods:						

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AND PLAN OF CORRECTION IDI		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY  COMPLETED	
		155637	B. WING 03/21/2011				
NAME OF P	PROVIDER OR SUPPLIER	<del></del>			DDRESS, CITY, STATE, ZIP CODE		
CHICAG	OLAND CHRISTIAN	√VILLAGE		1	117TH AVE N POINT, IN46307		
(X4) ID				ID I	5,	·	(X5)
PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TION SHOULD BE	
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	IE	COMPLETION DATE
	(2) Manufactur	er's calibrated					
	sensitivity test	instrument.					
	(3) Listed contr	ol equipment					
	arranged for th	e purpose.					
	(4) Smoke dete	ctor/control unit					
	_	hereby the detector					
		at the control unit					
		tivity is outside its					
	acceptable sens	· · ·					
		ated sensitivity test					
	method accepta						
	authority havin						
		d to have sensitivity					
	outside the list						
		e shall be cleaned					
	and recalibrate						
		ensitivity shall not					
		easured using any					
	device that adm						
	unmeasured co						
		e detector." This					
	deficient practi	ce affects all					
	occupants.						
	Findings includ	le:					
	Possal -	our of the 00/10/10					
		iew of the 08/12/10					
	· · · · · ·	ing Summary Test					
	Results with the						
	director on 03/						
	l • • • • • • • • • • • • • • • • • • •	t was incomplete.					
	The record note	ed each smoke					

001198

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155637			(X2) MULTIPLE CO  A. BUILDING  B. WING	NSTRUCTION	COMP	(X3) DATE SURVEY  COMPLETED  03/21/2011		
NAME OF PROVIDER OR SUPPLIER  CHICAGOLAND CHRISTIAN VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE CROWN POINT, IN46307					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	.D BE	(X5) COMPLETION DATE		
	should test, howere recorded recorded result detectors as Nodate for this Promotes and the second same locations results for smooth same locations results and were an undated Prior The maintenand date for sensition to be determined been sensitivity the contractor	hich each detector owever, the results as Prior Test and its for 21 smoke (A. There was no ior Test. Current re noted as N/A for otors. Reports from were compared (10 report. Test ike detectors at the had different re also recorded in or Test column. It is a column to the different re and it could not if all detectors had (10 rested) the called immediately. No on was forthcoming						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE S COMPL 03/21/2	ETED
NAME OF PROVIDER OR SUPPLIER CHICAGOLAND CHRISTIAN VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE CROWN POINT, IN46307				
PREFIX (EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
exceed 212 deg (F). This deficie affect occupant room smoke co the capacity for residents.  Findings includ  During observa at 12:05 p.m., to director said th heaters was pro building and he why a portable located in the a The maintenanc at the time of o no idea the spa and could not p the heating elei exceed the 212 could not provi	acility failed to the 1 of 1 space uipped with a t which would not grees Fahrenheit ent practice could the softhe dining tempartment with the more than 45  e:  tion on 03/21/11 the maintenance the use of space to hibited in the the could not explain space heater was the director also said the servation, he had the heater was there the rovide evidence the ment would not the de a written policy tion or use of space	KOO	070	K 0070 1. What is the correcti action taken for the resident found to be affected by the deficient practice? Space heat was removed immediately. 2 How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. A check throughout the facilty revealed other space heaters were in us 3. What measures will be put place or what system changes will be made to ensure that the deficient practice does not reoccur. An in-servcie regardin space heater will be presented the April all staff meeting. 4. How the corrective actions will monitored to ensure that the deficient practice will not reocci.e. what quality assurance will put in place. Space Heater observation will be part monthly preventative maintenal log observation. Log will be reviewed by the Maintenance Supervisor/Designee monthly findings will be rported to the Administrator /Designee who vereport findings to Q/A ongoing.	no se. into se at the bear of ace	04/20/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED		
155637		155637	B. WING			03/21/2011	
			B. ((1))		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				117TH AVE		
CHICAGOLAND CHRISTIAN VILLAGE				l	N POINT, IN46307		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL		ID PREFIX		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
K0144 SS=C	source of power NFPA 99, 3–6.3 emergency system so in the event normal power is source of power connect to the seconds. NFPA requires a writte inspection, per exercising periode regularly manavailable for instauthority havin deficient practic occupants.  Findings include Based on review monthly Emergency system.	d interview; the ensure for 1 of 1 ving as the alternate or was complete.  3.1.2 requires the tem to be arranged of failure of the source the alternate or will automatically load within 10 and 99, 3-5.4.2 ten record of formance, and and repairs shall aintained and spection by the g jurisdiction. This ce affects all	K01	44	K 01441. What is the correct action taken for the resident found to be affected by the deficient practice? Generator Testing is now being documen as starting within 10 seconds 2. How other residents have t potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All resider have potential to be affected by incorrect docuentation of generator testing 3. What measures will be put into place what system changes will be made to ensure that the deficient practice does not reoccur. Maintenance supervis will instruct other maintenace on generator testing and documentation 4. How the corrective actions will be monitored to ensure that the deficient practice will not reocci.e. what quality assurance will put in place. Maintenance Supervisor/Designee will monitor generator log monthly and report findings to Administrator/Designee who were port to Q/A. This monitoring be ongoing.	ted . he or ent sor staff	04/20/2011

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIE		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDING			COMPLETED	
		155637	B. WIN	NG		03/21/2	<u>2011</u>
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE	•	
					117TH AVE N POINT, IN46307		
CHICAGOLAND CHRISTIAN VILLAGE					N FOINT, IN40307		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO		.TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	director on 03	/21/11 at 1:50					
	p.m., documer	ntation for Switch					
	Time recorded	the transfer time as					
	"<25 sec." The	e maintenance					
		e was unaware he					
		ent a transfer within					
	10 seconds. A	demonstration of					
	the generator t	test by the					
	maintenance d	irector on 03/21/11					
	at 5:15 p.m., r	evealed the					
	•	in fact, transfer					
	within 10 seco						
	Within 10 3eto	iius.					
	3.1-19(b)						
			- 1				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

OVPC21 Facility ID:

ID: 001198

If continuation sheet